Health Net

MEMBER GRIEVANCE/COMPLAINT FORM

Date: _____

Please print all information.
Complainant information:

Name	( ) Work Telephone Number	( ) Home Telephone Number

Address	City	State	Zip Code

Name of person(s) related to complainant:

Name	ID Number #:
Name	ID Number #:
Name	ID Number

Nature of complaint: [Check all that apply]

_____ Marketing	_____ Difficulty disenrolling	_____ Member billing
_____ Quality	_____ Transportation	_____ Accessibility to care
_____ Emergency care	_____ Staff attitude	_____ Authorization

Other: _____

Problem statement: Date of Occurrence: _____ Location: _____
Provider Name _____
Describe the problem/complaint in detail:

_____

_____

_____

_____

Use the back of this form if additional space is needed.

_____ _____
Signature of Member Date
(or signature of parent where member is a minor or incapacitated)

MEDICAL RELEASE

MEMBER: Please provide name and telephone number of any providers who may have treated you for the condition, which is the subject of this grievance.

All Medical Records obtained will be held in strict confidence and used solely for reviewing your grievance.

I HEREBY AUTHORIZE AND REQUEST THE ABOVE LISTED PROVIDER(S) TO RELEASE ANY AND ALL MEDICAL RECORDS TO HEALTH NET SUPPORTING MEDICAL NECESSITY FOR THE SUBJECT OF THIS GRIEVANCE:

_____

SIGNATURE:_____ **DATE:** _____

(If signed by other than Member) RELATIONSHIP: _____
(MOTHER, FATHER, GUARDIAN)

If you should have any further questions or need additional assistance concerning this matter, please contact our Member Services Department toll free at (800) 675-6110 (TTY:711). When complete, please submit this form to: Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. Fax Number: (877) 831-6019.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-675-6110** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.